		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032961

Facility Name: SPRINGFIELD TERRACE

Address: 525 S. MARTIN LUTHER KING DR. (Number) SPRINGFIELD (City) 62703 (Zip Code)

County: SANGAMON

Telephone Number: (217) 789-1680 **Fax #** (217) 789-0842

IDPA ID Number: 37-1223350

Date of Initial License for Current Owners: 11/06/87

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[X] PROPRIETARY		[ ] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MELVIN SIEGEL
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	19,951	1,496		21,447	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,951	1,496		21,447	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.40%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/06/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/06/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	81,488	8,038	5,176	94,702		94,702	0	94,702			1
2	Food Purchase		79,640		79,640	(9,855)	69,785	(296)	69,489			2
3	Housekeeping	47,511	11,345	0	58,856		58,856	0	58,856			3
4	Laundry	21,302	7,546	405	29,253		29,253	0	29,253			4
5	Heat and Other Utilities			41,123	41,123		41,123	712	41,835			5
6	Maintenance	25,583	16,799	18,956	61,338		61,338	(4,468)	56,870			6
7	Other (specify):*			4,667	4,667		4,667	61	4,728			7
8	TOTAL General Services	175,884	123,368	70,327	369,579	(9,855)	359,724	(3,991)	355,733			8
	B. Health Care and Programs											
9	Medical Director	0		10,850	10,850		10,850	0	10,850			9
10	Nursing and Medical Records	491,906	19,757	8,255	519,918		519,918	6,228	526,146			10
10a	Therapy	0		250	250		250	0	250			10a
11	Activities	27,702	2,175	4,263	34,140		34,140	(3,209)	30,931			11
12	Social Services	37,265	1,050	0	38,315		38,315	0	38,315			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	556,873	22,982	23,618	603,473	0	603,473	3,019	606,492			16
	C. General Administration											
17	Administrative	54,800		0	54,800		54,800	12,186	66,986			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			113,703	113,703		113,703	(93,340)	20,363			19
20	Dues, Fees, Subscriptions & Promotions			8,446	8,446		8,446	(1,721)	6,725			20
21	Clerical & General Office Expenses	42,315	11,984	14,528	68,827		68,827	32,088	100,915			21
22	Employee Benefits & Payroll Taxes			104,556	104,556	9,855	114,411	0	114,411			22
23	Inservice Training & Education			2,075	2,075		2,075	134	2,209			23
24	Travel and Seminar			0	0		0	12,404	12,404			24
25	Other Admin. Staff Transportation			9,769	9,769		9,769	0	9,769			25
26	Insurance-Prop.Liab.Malpractice			23,696	23,696		23,696	1,131	24,827			26
27	Other (specify):*			0	0		0	9,627	9,627			27
28	TOTAL General Administration	97,115	11,984	276,773	385,872	9,855	395,727	(27,491)	368,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	829,872	158,334	370,718	1,358,924	0	1,358,924	(28,463)	1,330,461			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SPRINGFIELD TERRACE #0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,099	7,099		7,099	22,417	29,516			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			28,372	28,372		28,372	105,965	134,337			32
33	Real Estate Taxes			13,073	13,073		13,073	0	13,073			33
34	Rent-Facility & Grounds			114,989	114,989		114,989	(108,590)	6,399			34
35	Rent-Equipment & Vehicles			1,753	1,753		1,753	5,135	6,888			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			165,286	165,286	0	165,286	24,927	190,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			35,587	35,587		35,587	0	35,587			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	35,587	35,587	0	35,587	0	35,587			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	829,872	158,334	571,591	1,559,797	0	1,559,797	(3,536)	1,556,261			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,385	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(296)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(444)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,475)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(588)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(1,488)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (906)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,630)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,630)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,536)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SPRINGFIELD TERRACE

ID# 0032961

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -1488	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,488)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(296)	0	0	0	0	0	0	0	0	0	0	(296)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	712	0	0	0	0	0	0	0	0	0	712	5
6	Maintenance	(1,488)	(2,980)	0	0	0	0	0	0	0	0	0	(4,468)	6
7	Other (specify):*	0	61	0	0	0	0	0	0	0	0	0	61	7
8	**TOTAL General Services**	(1,784)	(2,207)	0	0	0	0	0	0	0	0	0	(3,991)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,228	0	0	0	0	0	0	0	0	0	6,228	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,209)	0	0	0	0	0	0	0	0	0	(3,209)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	3,019	0	0	0	0	0	0	0	0	0	3,019	16
	C. General Administration													
17	Administrative	0	10,207	1,979	0	0	0	0	0	0	0	0	12,186	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(93,340)	0	0	0	0	0	0	0	0	0	(93,340)	19
20	Fees, Subscriptions & Promotions	(2,063)	342	0	0	0	0	0	0	0	0	0	(1,721)	20
21	Clerical & General Office Expenses	(444)	0	32,532	0	0	0	0	0	0	0	0	32,088	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	134	0	0	0	0	0	0	0	0	134	23
24	Travel and Seminar	0	0	12,404	0	0	0	0	0	0	0	0	12,404	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,131	0	0	0	0	0	0	0	0	1,131	26
27	Other (specify):*	0	0	9,627	0	0	0	0	0	0	0	0	9,627	27
28	**TOTAL General Administration**	(2,507)	(82,791)	57,807	0	0	0	0	0	0	0	0	(27,491)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,291)	(81,979)	57,807	0	0	0	0	0	0	0	0	(28,463)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SPRINGFIELD TERRACE **#** 0032961 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,385	0	323	18,709	0	0	0	0	0	0	0	22,417	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	105,965	0	0	0	0	0	0	0	105,965	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,399	(114,989)	0	0	0	0	0	0	0	(108,590)	34
35	Rent-Equipment & Vehicles	0	0	5,135	0	0	0	0	0	0	0	0	5,135	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,385	0	11,857	9,685	0	0	0	0	0	0	0	24,927	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(906)	(81,979)	69,664	9,685	0	0	0	0	0	0	0	(3,536)	45

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	CHICAGO	CONSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES LTD		BOOKKEEPING
		PARK RIDGE TERRACE	LOVES PARK			
		PARKVIEW TERRACE	EAST MOLINE			
		SKYVIEW TERRACE	JACKSONVILLE			
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULT	$ 9,960			$	$ (9,960)	1
2	V	10	PSYCHO-SOCIAL CONSULT	3,393				(3,393)	2
3	V	11	ACTIVITY CONSULTANT	3,300				(3,300)	3
4	V	19	ADMIN./BKKP. FEES	77,640				(77,640)	4
5	V	19	ADMIN. CONSULT. FEES	17,638				(17,638)	5
6	V	5	ELECTRICITY				712	712	6
7	V	6	MAINTENANCE				6,980	6,980	7
8	V	7	SCAVENGER				61	61	8
9	V	10	PSYCHO-SOCIAL CONSULT				9,621	9,621	9
10	V	11	ACTIVITIES CONSULTANT				91	91	10
11	V	17	ADMIN. SALARIES/MGMT				10,207	10,207	11
12	V	19	PROFESSIONAL FEES				1,938	1,938	12
13	V	20	ADVERTISING				342	342	13
14	Total			$ 111,931			$ 29,952	$ * (81,979)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	$	MAVIN ENTERPRISES, LTD.		$ 32,532	$ 32,532	15
16	V	23	SEMINARS				134	134	16
17	V	24	TRAVEL				12,404	12,404	17
18	V	26	INSURANCE				1,131	1,131	18
19	V	27	EMPLOYEE BENEFITS				9,627	9,627	19
20	V	30	DEPRECIATION				323	323	20
21	V	34	OFFICE RENT				6,399	6,399	21
22	V	35	EQUIPMENT RENT				5,135	5,135	22
23	V	17	MGMT FEES-SWS				1,979	1,979	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 69,664	$ * 69,664	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 114,989	IDES ASSOCIATES		$	$ (114,989)	15
16	V	30	DEPRECIATION				18,709	18,709	16
17	V	32	INTEREST				105,965	105,965	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 114,989			$ 124,674	$ * 9,685	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6			SEE ATTACHED LIST								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAVIN ENTERPRISES, LTD.
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY	PATIENT DAYS	151,711	7	$ 5,036	$	21,447	$ 712	1
2	6	MAINTENANCE	PATIENT DAYS	151,711	7	49,373		21,447	6,980	2
3	7	SCAVENGER	PATIENT DAYS	151,711	7	432		21,447	61	3
4	10	PSYCHO-SOCIAL CONSULT	PATIENT DAYS	151,711	7	68,057		21,447	9,621	4
5	11	ACTIVITIES CONSULTANT	PATIENT DAYS	151,711	7	646		21,447	91	5
6	17	ADMIN. SALARIES/MGMT	PATIENT DAYS	151,711	7	72,200	72,200	21,447	10,207	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	151,711	7	13,709		21,447	1,938	7
8	20	ADVERTISING	PATIENT DAYS	151,711	7	2,417		21,447	342	8
9	21	TOTAL OFFICE	PATIENT DAYS	151,711	7	230,125	144,338	21,447	32,532	9
10	23	SEMINARS	PATIENT DAYS	151,711	7	950		21,447	134	10
11	24	TRAVEL	PATIENT DAYS	151,711	7	87,742		21,447	12,404	11
12	26	INSURANCE	PATIENT DAYS	151,711	7	8,000		21,447	1,131	12
13	27	EMPLOYEE BENEFITS	PATIENT DAYS	151,711	7	68,102		21,447	9,627	13
14	30	DEPRECIATION	PATIENT DAYS	151,711	7	2,285		21,447	323	14
15	34	OFFICE RENT	PATIENT DAYS	151,711	7	45,262		21,447	6,399	15
16	35	EQUIPMENT RENT	PATIENT DAYS	151,711	7	36,325		21,447	5,135	16
17	17	MGMT FEES - SWS	PATIENT DAYS	151,711	7	14,000		21,447	1,979	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 704,661	$ 216,538		$ 99,616	25

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IDEA ASSOCIATES
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COST	1	1	$ 18,709	$	1	$ 18,709	1
2	32	INTEREST	DIRECT COST	1	1	105,965		1	105,965	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 124,674	$		$ 124,674	25

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	RELATED PARTY						$	$			$	1
2	IDEA											2
3	SUCCESS NATIONAL BANK			MORTGAGE	DEMAND	10/98	874,500	858,054	10/03	9.5000	105,965	3
4												4
5												5
	Working Capital											
6	SUCCESS NATIONAL BANK		X	WORKING CAPITAL		11/07/97	150,000	197,475		10.5000	9,472	6
7	IDEA ASSOCIATES	X		DEBT CONSOLIDATION		10/18/98	377,424	197,014		9.5000	18,900	7
8												8
9	TOTAL Facility Related						$ 1,401,924	$ 1,252,543			$ 134,337	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 1,401,924	$ 1,252,543			$ 134,337	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 13,008	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 13,073	2
3. Under or (over) accrual (line 2 minus line 1).		$ 65	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 13,008	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 13,073	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	11,883	8
	1997	12,193	9
	1998	12,374	10
	1999	13,008	11
	2000	13,073	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SPRINGFIELD TERRACE COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0032961

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-35.0-157-019	NURSING HOME	$ 13,073.16	$ 13,073.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,073.16	$ 13,073.16

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 0 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 0 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1987	$ 22,340	1
2					2
3	TOTALS			$ 22,340	3

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1987		$ 589,342	$ 18,709	31.5	$ 18,709	$	$ 209,418	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1991	3,905	124	20	196	72	1,936	9
10	VARIOUS			1992	8,184	260	20	409	149	3,523	10
11	VARIOUS			1993	750	19	20	38	19	269	11
12	VARIOUS			1994	540	13	20	27	14	203	12
13	DOOR			1997	1,086	27	20	54	27	239	13
14	SPRINKLER			1997	3,790	97	20	189	92	835	14
15	DECORATING			1997	2,281	58	20	114	56	513	15
16	EXHAUST SYTEM			1997	1,250	32	20	62	30	295	16
17	TILE			1997	1,944	49	20	97	48	485	17
18	TILE			1997	638	16	20	32	16	139	18
19	DOORS			1997	1,327	35	20	66	31	275	19
20	SPRINKLER			1997	705	18	20	35	17	149	20
21	SPRINKLER			1997	1,532	40	20	77	37	325	21
22	REWIRE & REPLACE SECURITY			1997	3,000	77	20	150	73	613	22
23	SPRINKLER			1998	2,138	56	20	107	51	374	23
24	DOORS			1998	1,896	49	20	95	46	332	24
25	SECURITY SYSTEM			1998	1,149	30	20	57	27	228	25
26	FLOOR TILE, LIGHTS			1999	1,468	38	20	73	35	219	26
27	SHINGLE ROOF			2000	26,800	974	27.5	974		1,770	27
28	NEW AIR CONDITIONERS			2000	2,255	82	27.5	82		149	28
29	FRONT DOOR WITH LOCK			2000	1,245	46	27.5	46		83	29
30	REPLACE 3 TON CONDENSING UNIT FOR LUNCH ROOM			2001	3,494	64	27.5	64		64	30
31	GUTTERS AND DOWNSPOUTS			2001	2,654	48	27.5	48		48	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 663,373	$ 20,961		$ 21,801	$ 840	$ 222,484	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 70,328	$ 3,545	$ 5,944	$ 2,399	8-10	$ 55,618	71
72	Current Year Purchases	1,825	260	182	(78)	5	182	72
73	Fully Depreciated Assets				0			73
74	MAVIN ALLOCATION		323	323	0			74
75	TOTALS	$ 72,153	$ 4,128	$ 6,449	$ 2,321		$ 55,800	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1997 FORD LTD	1992	$ 1,795	$ 0	$ 180	$ 180	10	$ 1,785	76
77	FACILITY	1998 CHEVROLET VAN	1999	5,429	1,042	1,086	44	5	3,257	77
78							0			78
79							0			79
80	TOTALS			$ 7,224	$ 1,042	$ 1,266	$ 224		$ 5,042	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 765,090	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,131	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,516	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,385	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 283,326	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,753 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 700	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	445,772		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,919		6
7	Other Prepaid Expenses	14,948		7
8	Accounts Receivable (owners or related parties)	306,117		8
9	Other(specify): Real Estate Escrow Deposit	10,244		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 789,700	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	74,032		15
16	Equipment, at Historical Cost	77,581		16
17	Accumulated Depreciation (book methods)	(77,743)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	1,350		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 75,220	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 864,920	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 261,092	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	866,249		29
30	Accrued Salaries Payable	33,879		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,029		31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,008		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,176,257	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,176,257	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (311,337)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 864,920	$ 0	48

***(See instructions.)**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (315,230)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (315,230)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	3,920	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) TREASURY STOCK	(27)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,893	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (311,337)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,563,717	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,563,717	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,563,717	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	369,579	31
32	Health Care	603,473	32
33	General Administration	385,872	33
	B. Capital Expense		
34	Ownership	165,286	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	35,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,559,797	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,920	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,920	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,037	2,339	$ 45,791	$ 19.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	663	662	11,205	16.93	3
4	Licensed Practical Nurses	9,685	9,867	149,875	15.19	4
5	Nurse Aides & Orderlies	27,879	30,067	260,383	8.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,396	3,561	27,702	7.78	10
11	Social Service Workers	3,580	3,964	37,265	9.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,479	11,027	81,488	7.39	15
16	Dishwashers					16
17	Maintenance Workers	2,734	2,830	25,583	9.04	17
18	Housekeepers	7,474	7,725	47,511	6.15	18
19	Laundry	2,896	3,105	21,302	6.86	19
20	Administrator	1,942	2,069	54,800	26.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,263	6,373	42,315	6.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Care PlanCoordin	1,304	1,506	24,652	16.37	33
34	TOTAL (lines 1 - 33)	80,332	85,095	$ 829,872 *	$ 9.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,176	1-3	35
36	Medical Director	O	10,850	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	134	10-3	38
39	Pharmacist Consultant	H	841	10-3	39
40	Physical Therapy Consultant	L	250	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	4,263	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47		S			47
48					48
49	TOTAL (lines 35 - 48)		$ 21,514		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	66	2,087		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	66	$ 2,087		53

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CARLYN CAMINQUE	ADMIN	0	$ 54,800
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 54,800

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
GARY A. WEINTRAUB	LEGAL FEES	$ 4,788
KRUPNICK, BOKOR	ACCOUNTING FEES	4,150
SUCCESS NATIONAL BANK	AUDIT	1,225
PERSONNEL PLANNERS	UC CONSULTANT	1,124
ALPHA DATA SERVICES	DATA PROCESSING	1,948
NURSING CARE SYSTEMS	DATA PROCESSING	3,120
MAVIN ENTERPRISES	ADM. CONSULTANT	17,638
MAVIN ENTERPRISES	BOOKKEEPING/ADMIN.	77,640
MID AMERICA PROGRAM	DATA PROCESSING	1,320
ACE TAX & LEGAL CONSULT	LEGAL FEES	750
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 113,703

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,299
Unemployment Compensation Insurance	12,490
FICA Taxes	63,834
Employee Health Insurance	5,859
Employee Meals	9,855
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,074
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 114,411

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,373
Health Care Worker Background Check	1,026
(Indicate # of checks performed 85)	
MARKETING/ADV/PROMO	588
MGMT CO ALLOCATION	342
CONTRIBUTIONS	1,475
DUES & SUBSCRIPTIONS	2,656
LICENSES & PERMITS	128
TRUST FEES/CONTRIBUTIONS	(1,475)
Less: Public Relations Expense	(0)
Non-allowable advertising	(588)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,725

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	12,404
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,404

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	7//2001	$ 1,785	3 YRS	$	$	$	$ 297	$ 595	$ 595	$ 298	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,785		$	$	$	$ 297	$ 595	$ 595	$ 298	$	$

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YEST**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $2461**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,587**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,855** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: SPRINGFIELD TERRACE **#0032961** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,176	
	REPAIRS & MAINTENANCE		0	
			0	5,176
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		405	
			0	405
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		5,676	
	ELECTRICITY		19,847	
	WATER		14,916	
	CABLE TV - LOBBY		684	
			0	41,123
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,585	
	PAINTING & DECORATING		1,785	
	BUILDING REPAIRS		1,568	
	MAINTENANCE CONSULTANT		9,960	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,367	
	FIRE SERVICE		1,691	
			0	
			0	
			0	18,956
7	**OTHER**			
	SCAVENGER		3,648	
	SECURITY SERVICE		1,019	4,667
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	10,850	10,850

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	2,087	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	5,193	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	841	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	134	
			0	
			0	8,255
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	250	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	250
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,263	
			0	4,263
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SPRINGFIELD TERRACE **#0032961** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,388	
	ADMINISTRATIVE CONSULTANTS	XIX C	17,638	
	PROFESSIONAL FEES	XIX C	12,037	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		77,640	113,703
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	588	
	EMPLOYEE WANT ADS	XIX F	2,373	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	2,656	
	LICENSES & PERMITS	XIX F	328	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,475	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,026	8,446
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		1,516	
	EQUIPMENT REPAIR & MAINTENANCE		245	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	444	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,323	
	MESSENGER SERVICE		0	
			0	14,528

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	63,834	
	UNEMPLOYMENT COMPENSATION	XIX D	12,490	
	WORKERS COMPENSATION INSURANC	XIX D	20,299	
	HOSPITALIZATION INSURANCE	XIX D	5,859	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,074	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	104,556
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,075	2,075
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,769	9,769
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		23,696	23,696
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 370,718

SPRINGFIELD TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	79,640
LESS SALES TAX	(296)
NET FOOD	79,344
TOTAL PATIENT CENSUS	21,447
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	64341
ADD # EMPLOYEE MEALS/DAY	25
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	9125

PATIENT MEALS	64341
ADD EMPLOYEE MEALS	9125
TOTAL MEALS/YEAR	73466
NET FOOD	79344
DIVIDE TOTAL MEALS/YEAR	73466
COST PER MEAL	1.08
TIME EMPLOYEE MEALS	9125
EMPLOYEE MEAL RECLASSIFICATION	9855